STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 87406-001**

v

Physicians Health Plan of Mid-Michigan TPA
Respondent
_____/

Issued and entered
This 5th day of March 2008
by Ken Ross
Commissioner

ORDER
I
PROCEDURAL BACKGROUND

On January 28, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services under Public Act No. 495 of 2006, MCL 550.1951 et seq. On February 4, 2008, after a preliminary review of the material submitted, the Commissioner determined the Petitioner was eligible for an external review and accepted the request.

Section 2(2) of Act 495, MCL 550.1952(2), requires the Commissioner to conduct this external review as though the Petitioner were a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Petitioner is enrolled for health care coverage through his employment at Michigan State University, a local unit of government self-funded plan under Act 495 that is administered by Physicians Health Plan of Mid-Michigan TPA (PHPTPA).

The issue in this external review can be decided by analyzing the contractual terms of the Petitioner's health care coverage. That coverage is defined in a Benefits Plan Booklet (the

booklet) issued by PHPTPA. The Commissioner reviews contractual issues under MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

On May 25 and July 26, 2007, the Petitioner received services from Dr. XXXXX, a non-network provider. PHPTPA covered the services but applied a portion of the eligible charges to the Petitioner's 2007 non-network deductible and coinsurance. The Petitioner appealed, asking PHPMM to pay the claims at the network level. PHP maintained its determination on the claims.

The Petitioner exhausted PHPTPA's internal grievance process and received its final adverse determination letter dated December 21, 2007.

III
ISSUE

Did PHPTPA properly process the Petitioner's claims from Dr. XXXXX?

IV
ANALYSIS

Petitioner's Argument

The Petitioner disagrees with PHPTPA's decision to apply charges for Dr. XXXXX's services to his non-network deductible and coinsurance, leaving him responsible for paying a large portion of the charges. The Petitioner says he went to Dr. XXXXX, who treated him following his heart attack four years ago, because he is comfortable with him.

The Petitioner argues that PHPTPA should provide in-network coverage for the services because Dr. XXXXX' office never told him that he would have out-of-pocket costs. The Petitioner wants PHPTPA to process his claims and pay them as an in-network benefit and not apply the non-network deductible and coinsurance.

PHPTPA's Argument

In its final adverse determination, PHPTPA said:

> Your appeal was denied because your claims for Dr. XXXXX [were] processed using your Non-Network coverage, which has an annual deductible of $500.00 per member and not more than $1000.00 per family per calendar year. The covered percentage for a physician office visit, after satisfaction of the annual deductible, is 80% of eligible expenses according to the terms, conditions, and limitations of your Benefit Plan Booklet.

PHPTPA cites these provisions relating to annual deductibles and eligible expenses in *Section 1: What's Covered – Benefits* of the booklet:

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Service before you are eligible to receive Benefits. * * *	**Network** No Deductible **Non-Network** $500 per covered Person per calendar year, not to exceed $1000 for all Covered Persons in a family

> **Eligible Expenses**
>
> Eligible Expenses are the amount we determine that we will pay for Benefits. * * * For Non-Network benefits, you are responsible for paying directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.

The booklet also explains (on page 26) that physician office services from a non-network provider are subject to a copayment of 20% of PHPTPA's eligible amount for those services. Since Dr. XXXXX is a non-network provider, PHPTPA says it applied the eligible charges for his services first to the Petitioner's $500.00 non-network deductible and then applied the 20% non-network copayment before making its payment.

Commissioner's Review

The Petitioner explained during PHPTPA's internal grievance process that he wanted to continue to see Dr. XXXXX because the doctor treated him when he had a heart attack in 2003 and he trusts him. However, it is undisputed that Dr. XXXXX is not in PHPTPA's network, and since the Petitioner has not argued or shown that services performed by Dr. XXXXX were not

available from a network provider, the charges for those services must be processed as non-network benefits subject to the deductible and 20% copayment requirements.

The claims history forms in the record show that PHPTPA processed the Petitioner's claims as shown in this table:

Date of Service	Provider Charge	PHPTPA's Eligible Amount	Paid by PHPTPA	Petitioner's Responsibility		
				Amount Applied to Deductible	Coinsurance (20% of eligible expenses after deductible)	Balance of Provider Charge
5/25/07	$ 105.00	$ 97.70	$ 0.00	$ 97.70	$ 0.00	$ 7.30
7/26/07	1,837.00	1,410.51	806.58	402.30	201.63	426.49
Totals	$1,942.00	$1,508.21	$806.58	$500.00	$201.63	$433.79

The Petitioner's coverage allows him to choose to receive medically necessary services from either network or non-network providers. However, services from non-network providers come with significantly higher out-of-pocket costs. The booklet (page 51) says that while prior notification is not always required, "Non-Network Benefits are generally paid at a lower level than Network Benefits."

Dr. XXXXX charged $1,942.00. PHPTPA applied the first $500.00 of eligible amount ($1,508.21) for the services to the Petitioner's deductible. The booklet is clear that a $500.00 deductible applies if a member has covered services from a non-network provider (unless the service is for an emergency, which is not shown to be the case here). Then PHPTPA applied the 20% copayment to the balance of the eligible amount as required by the terms of his non-network coverage. The Petitioner also remained liable for any difference between Dr. XXXXX's charge and PHPTPA's eligible amount. As a result, the Petitioner was responsible for $1,135.42 of the total charge.

It is the Petitioner's contention that Dr. XXXXX's office did not tell him that he would have to pay a portion of the cost for the care he received. However, the Commissioner's decision in this case cannot be based on the content of any conversations the Petitioner had with the doctor's office; it must be based on the terms and conditions of the Petitioner's coverage. The booklet, not the doctor's office, explains how non-network providers are paid.

After careful review of the record, including the booklet, the Commissioner finds that PHPTPA correctly applied the deductibles and copayments for the Petitioner's services from a non-network provider according to the terms and conditions of the Petitioner's coverage.

V
ORDER

The Commissioner upholds PHPTPA's December 14, 2007, final adverse determination in this case. PHPTPA properly applied the deductible and copayment for the services obtained from a non-network provider under the terms of its coverage.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County.

A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.